ECHO HILL OUTDOOR SCHOOL

Summer Residential Health and Registration Form

To be filled out by parents - please print clearly and complete both sides

Your School/Group's Name:	**Date(s) Attending EHOS:**
Gender: **Grade:**	**Age:** **Date of Birth:**

Child's Name (please print one letter per box):

Parent or Guardian #1 Name:

Parent or Guardian #2 Name:

Child's Home Address - Street:

Child's Home Address - City, State, Zip Code:

Home Phone:

Parent or Guardian's E-Mail Address:

Parent or Guardian's Cell Phone:

Parent or Guardian #1 Employer:	Work Phone:
Parent or Guardian #2 Employer:	Work Phone:
Person to Contact in Emergency (other than parent):	Phone:
Name of Child's Physician:	Phone:
Name of Family's Medical Insurance Company:	Policy Number:

Health Information Necessary for Child's Protection and Care:

Please circle Yes or No. If Yes please provide details; use separate page if necessary

1. Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity while at the Outdoor School? YES NO Provide Details:_____

- Recent surgery or illness: YES NO Date & Details: _____
- Recent broken bones or sprains: YES NO Date & Details: _____
- Recent childhood diseases or infectious diseases: YES NO Date & Details: _____
- Asthma, heart condition, diabetes, seizure: YES NO Date & Details: _____
- Other physical conditions: YES NO Date & Details: _____
- Allergies to Medications: YES NO Details: _____
- Allergies to Foods: YES NO Details: _____
- Environmental allergies (bee stings, hayfever, etc.): YES NO Details: _____

2. To help us supervise your child at the Outdoor School, the following information is necessary.

- Does your child sleepwalk? YES NO Details: _____
- Does your child wet the bed at night? YES NO Details: _____
- Has your child been away from home alone before? YES NO Details:_____
- Are there any mental, emotional, or social factors that may affect the care of your child while at the Outdoor School? YES NO Please Describe:_____

Please Complete Both Sides

Medical Information

ALL medication, prescription or otherwise, must be clearly labeled with child's name.
All medication must be in original container or it CANNOT be accepted by state guidelines.

Has your child had a Tetanus shot?	YES NO	Date of last Tetanus shot: ___/___/_____	
May have Tylenol if needed?	YES NO		mm/dd/yyyy
May have Benadryl for life-threatening emergency?	YES NO	May apply sunscreen?	YES NO
May have Benadryl for allergic reaction?	YES NO	Parent will provide _____ sunscreen	
		list brand	

[ ] My child is not bringing medication.	[ ] My child takes medication as listed.
My child will be bringing an Epi-Pen YES NO Reason:	My child will be bringing an Albuterol Inhaler (for PRN or as needed) YES NO

Echo Hill requires Epi-Pens and PRN Inhalers to be carried at all times.
Please provide a fanny/waist pack for carrying.

Name of Medication	Approximate Time	Condition/Reason
1.		
2.		
3.		

Immunization Information

For Students Who Reside WITHIN the United States, a U.S. territory or the District of Columbia:	**For Students who Reside OUTSIDE the United States, a U.S. territory, or the District of Columbia:**
1. State/territory in which student resides: 2. Is this student exempt from any immunizations? [ ] No [ ] Yes If Yes, list them:	1. Country in which student resides: 2. Attach State of Maryland Form DHMH-896 (record of vaccination or immunity)

The following box must be completed and signed for your child to attend

This health history is correct so far as I know, and the person herein described has permission to engage in all activity, except as noted by me.

If a serious emergency occurs, it might be necessary for a physician to attend to your child before the Echo Hill Outdoor School staff is able to contact you or your designated physician. Such care can be provided ONLY if you will sign the following AUTHORIZATION FOR MEDICAL TREATMENT:

I hereby give permission to the physician selected by the director of Echo Hill Outdoor School to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. I understand that the health insurance policy which I carry on my child is the primary policy in case of any illness or injury. Echo Hill Outdoor School carries an excess policy which covers expenses not paid by my primary family insurance, including deductibles and co-pays up to our limit.

I understand that the program my child is participating in may involve specialized activities (boating, canoeing, low and high ropes challenge course.) I give permission for my child to participate in these activities and to be transported by Echo Hill Outdoor School for these activities. I know and understand the inherent risks and dangers involved in the above named activities and I understand that although EHOS will take reasonable precautions, it is impossible to guarantee absolute safety, and that unanticipated dangers might arise. I hereby release EHOS from any responsibility for injury which might occur as a result of participation in EHOS activities.

I give Echo Hill Outdoor School permission to reproduce and publish any photo, picture, video, or likeness of my child for the purpose of enhancing enrollment and/or marketing.

Signature _____ Date _____

Relationship to child _____

A signed, printed copy of this form must accompany your child.

4 & 5 DAY EXPLORE TRIPS
CLOTHING AND EQUIPMENT LIST

Due to limited storage space, this is a complete clothing and equipment list. Please pack everything except your sleeping bag in a waterproof duffel. Your sleeping bag should be in a separate waterproof bag. (If you do not have a waterproof duffel --- pack your equipment in a heavy-duty plastic trash bag and then put inside a duffel.)

**1 pair water shoes
2 pair summer shoes (sneakers, sandals)
2 pair long pants
2 long sleeved shirts
4 T-shirts
1 sweater or sweatshirt
2 bathing suits
3 pair shorts
3 pair socks
1 hat with visor
4 sets underwear
1 lightweight sleeping bag (in addition, you may want to bring a twin size flat sheet)
1 towel
summer pajamas
rain gear
sunglasses
biodegradable soap (Ivory)
toothpaste and toothbrush
insect repellent (NON-AEROSOL) cream or lotion
sunscreen
chapstick
pocket-size flashlight
water bottle
an extra plastic trash bag liner

OPTIONAL: fishing gear, camera, books, note pad and pen, spare batteries, inflatable pillow or one no larger than 12x12, musical instruments.

PLEASE DO NOT BRING: food-candy-gum, knives, money, mirrors, glass, cell phones, electronic games, iPods, iPads, etc!

**NOTE: A pair of sneakers, sandals and a pair of water shoes may seem like too much, but it is our strong recommendation:

1. Sneakers or tennis shoes are extremely comforting at the end of a long, wet day.
2. Sandals, Tevas, Clogs or Crocs are great around camp or on the boat during the day, but they <u>Do Not</u> substitute for water shoes while wading and swimming.
3. Water shoes are what we highly recommend for wading and swimming in the river. Water shoes will stay on your feet, allowing for free and protected wading and swimming in the sandy/muddy river bottom.
4. Slip-on water shoes are inexpensive and can be found in most stores and online shopping sites.

Please do your best to have your child attend with our recommendation for footwear.

DIRECTIONS/MAP TO DROP OFF/PICK UP LOCATION
4 & 5 Day Explore Trips

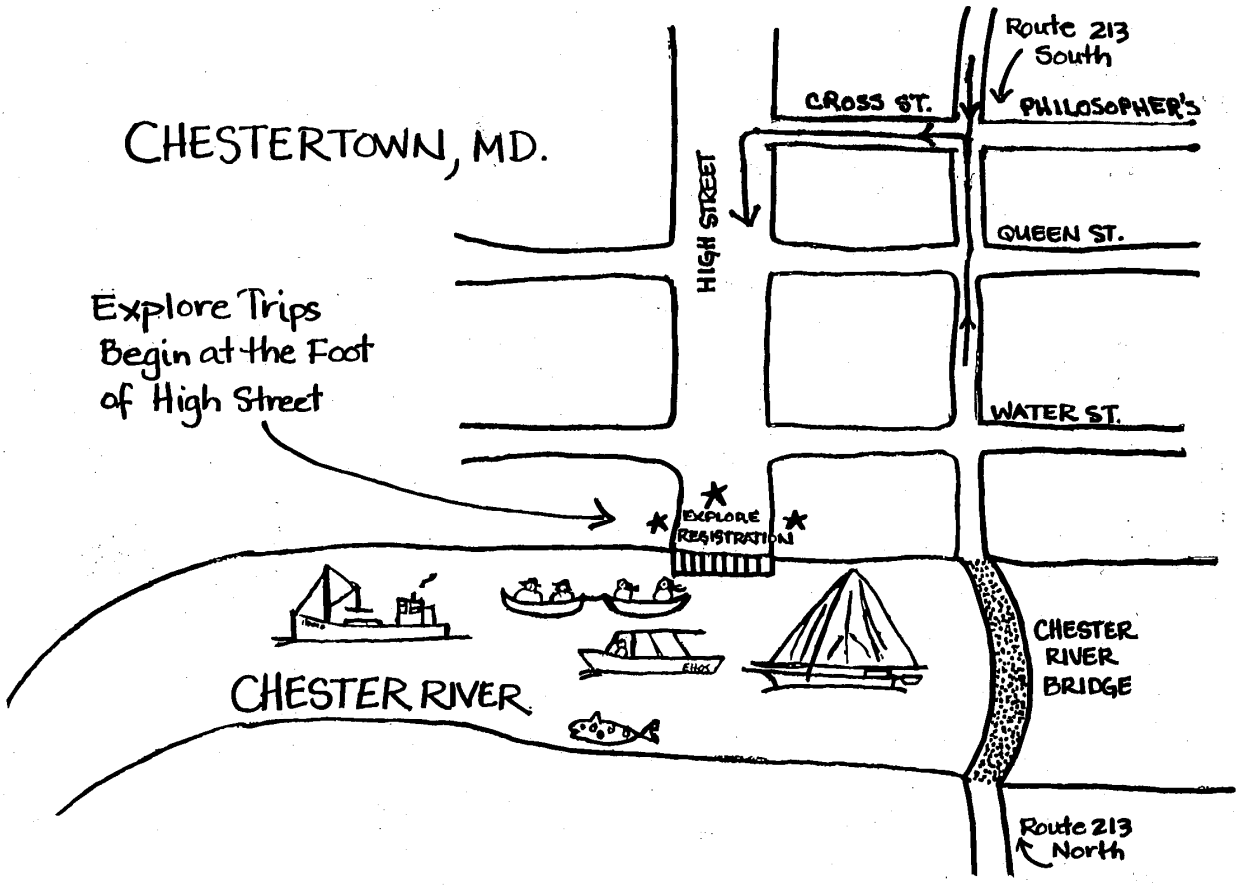
Drop Off: Monday, 10:00 - 11:00 a.m.
Pick Up: Thursday (4 day trip) or Friday (5 day trip), 3:00 - 3:30 p.m.

FROM PHILADELPHIA:

I-95 South to Elkton, Md. Exit. Go through Elkton and get on Route 213 South. Follow to Galena. In Galena turn right at traffic light to stay on Route 213 South. Continue on Route 213 South into Chestertown. Turn right at the traffic light onto Cross Street. Turn left at the next traffic light onto High Street. Continue to the foot of High Street.

FROM BALTIMORE AND WASHINGTON:

Take Route 50 past Annapolis and across the Bay Bridge. Follow Route 50 to junction of Route 301. Stay on Route 301 North to the Route 213 North exit. Follow 213 North to Chestertown. After crossing over the Chester River turn left at the traffic light onto Cross Street. Turn left at the next traffic light onto High Street. Continue to the foot of High Street.



MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-DHMH ext. 8417

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.

Prescription medication must be in a container labeled by the pharmacist or prescriber.

Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.

An adult must bring the medication to the camp and give the medication to an adult staff member.

I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME		2. DATE OF BIRTH ___/___/___ Month Day Year
3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		4. EMERGENCY MEDICATION [ ] YES *-If yes, see Section III below.* [ ] NO
5. MEDICATION NAME	6. DOSE	7. ROUTE
8. TIME/FREQUENCY OF ADMINISTRATION	9. IF PRN, FREQUENCY	
10. IF PRN, FOR WHAT SYMPTOMS		
11. KNOWN SIDE EFFECTS SPECIFIC TO CHILD		
12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is ***NOT TO EXCEED 1 YEAR.***	12a. FROM ___/___/___ Month Day Year	12b. TO ___/___/___ Month Day Year

13. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	

14a. PRESCRIBER'S SIGNATURE ***(Parent/guardian cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*	14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator/staff to administer the medication or supervise the camper in self administration if authorized as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA.

15a. PARENT/GUARDIAN SIGNATURE		15b. DATE
15c. HOME PHONE #	15d. CELL PHONE #	15e. WORK PHONE #

III. AUTHORIZATION FOR SELF ADMINISTRATION / SELF CARRY (OPTIONAL)

This section should only be completed if this medication is approved for self administration. Self carry is only permitted for emergency medications such as inhalers, insulin and epinephrine. Both the prescriber and the parent/guardian must consent to self administration below. However, youth camp operators are not required to permit self administration or self carry.

I consent that the child named above is able to self administer the medication listed. I authorize self administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. If indicated below, the child named above may self carry emergency medication.

16a. PRESCRIBER'S SIGNATURE authorizing self administration	16b. SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self administration	17b. SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	17c. DATE

MEDICATION ADMINISTRATION FORM

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

I. FACILITY RECEIPT AND REVIEW			
MEDICATION RECEIVED FROM			DATE
PLAN OF ACTION RECEIVED [ ] YES [ ] NO [ ] N/A		HEALTH SUPERVISOR NOTIFIED [ ] YES [ ] NO	
MEDICATION RECEIVED BY	PERSON'S SIGNATURE		DATE

II. MEDICATION ADMINISTRATION RECORD

Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to Administer:**

DATE	TIME	DOSAGE	REACTION OBSERVED (IF ANY)	STAFF OR SELF ADMINISTERED	ADMINISTERED OR SUPERVISED BY SIGNATURE

MEDICATION FINAL DISPOSITION FORM

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

I. FINAL DISPOSITION OF MEDICATION	
Child's Name:	**Date of Birth:**
Medication Name:	**Final Disposition:** [ ] **Returned** *(Complete Section A)* [ ] **Destroyed** *(Complete Section B)*
Section A	
MEDICATION RETURNED TO:	**DATE**
MEDICATION RETURNED BY (PERSON'S SIGNATURE)	**DATE**
Section B	
The above indicated medication was not retrieved by the parent/guardian within 1 week of the camper leaving camp; therefore, it has been destroyed according to COMAR 10.16.06.33.	
SIGNATURE OF PERSON RESPONSIBLE FOR DESTROYING MEDICATION	**DATE**
SIGNATURE OF PERSON WITNESSING THE DESTRUCTION OF THE MEDICATION	**DATE**